



ORIGINAL ARTICLE

A critical approach to subjectivation processes in psychiatry and their correlation with distinct political ideas

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Psychiatric practice is related to ways of constructing and defining subjectivity. Changes occurring in the psychiatric field, which include an increase in pathologies, the pluralization of psychotherapies and the development of neuroscientific approaches, have been changing how the subject relates with him or herself.

Based on a critical stance and analyzing significant psychotherapy texts, this article reflects on the subjectivation processes and ethical prescriptions present in the psychiatric field, which in a Foucauldian perspective mean how the subjects must relate with themselves.

As a result, different ethical prescriptions that have become dominant in the therapeutic ward are distinguished, namely: imposition of a subject's truth, self-knowledge, transformation, control and improvement. Although these prescriptions are not totally opposed to one another, and sometimes are present simultaneously in the psychiatric field, this article proposes that they are related to different political rationalities and processes of resistance and domination which are never entirely separated.

Keywords: Psychiatry, Subjectivation processes, Technologies of the Self, Michel Foucault, Ethical prescription

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INTRODUCTION

Since the last half of 19th century, the subject has been defined according to concepts that, not being exclusively psychiatric, are characteristic of the psychiatric domain. Therefore, a subject has emotions, thoughts, personality, identity, autonomy and individuality. Besides this, psychiatric practices and technologies (Foucault, 1997) define and mold how the subject should feel, think and act. The subject's relationship with these technologies is not only one of submission, but the subject himself modifies them, adhering to them or rejecting them, recreating himself through their incorporation (Hacking, 1995). Examples of such technologies include observation, listening, writing, psychological tests, classification, psychotherapy and pharmacotherapy. Since the second half of the 20th century, the emergence of community psychiatry, new psychotherapies, new pharmacotherapies and neurosciences insights has been modifying the processes of subjectivation in psychiatry. Generally, psychiatric consultations imply a prescription, which is not only a medication, but also dictates how the subject should relate with himself and his truth, how he should act and live. This amounts

to an ethical prescription, as ethics concerns itself both with acting according to values and how those values are produced and made true (Revel, 2016). An ethical prescription amounts to a normative stance and order how humans ought to think, feel and behave regarding the kind of relationship that they should have with themselves (Foucault, 1984)

This article analyses significative texts of psychotherapies in order to reflect on the processes of subjectivation in the psychiatric field and their correlate prescriptions. It will trace the development of these processes, from the imposition of a truth external to the subject to that of its discovery by the subject. It will also consider the ways in which the critique of the subject has influenced psychiatry, for instance in the absence of a pre-defined subject in therapy. However, if the subject can transform himself he can also control and improve himself. In the last sections, it will dwell on these two prescriptions.

DISCUSSION

From the imposition of truth to its knowledge

Psychiatry emerged as a disciplinary institution, where power was individualized

and the subject was exposed to permanent surveillance. In asylum psychiatry, the subject was governed through constant visibility, writing, interrogation and confession, and the hospital appeared as a place of observation and testing (Foucault, 2003). It was the place for the production of the subject's truth. So, the subject was the result of something previous to himself, the idea of a normal subject, by which he should be governed, having to tell the truth to achieve healing. This truth was not an inner truth, but the recognition of an imposed biographical truth in which healing took place when the subject recognized himself as ill and renounced his own self. Thus, the truth of the subject was the truth of the medical device, which had to be recognized and incorporated by the subject. Like in the Christian domain, obedience to the master, renunciation to his own self and the ideal of verbalization were the central aspects of such practice.

The emergence of psychoanalysis was associated with a new relationship between subjectivity and truth, in which there was an inner truth of the subject that had to be discovered and revealed, according to the imperative of self-knowledge. Through the relationship with the psychoanalyst, the subject has the duty to discover and analyze his hidden desires and scrutinize his unconscious. According to Sigmund Freud (2010/1940, p.42), the loss of self-knowledge was one of the causes of the loss of power of the ego, and it should be recovered during therapy:

"The method by which we strengthen the weakened ego has as a starting-point an extending of its self-knowledge. That is not, of course, the whole story but it is a first step. The loss of such knowledge signifies for the ego a surrender of power and influence; it is the first tangible sign that it is being hemmed in and hampered by the demands of the id and the super-ego"

The work of the analyst is to encourage and direct the patient towards rationality, interpreting his dreams, memories and errors, helping the patient to elaborate his conflicts and overcoming super-ego resistance. The analyst has his own knowledge, that is superior to the patient's knowledge, and should share his insights with the patient in a careful and dosed way. In this excerpt, Sigmund Freud (2010/1940, p.36)

enhances the importance of dyad between analyst and patient:

"The analytic physician and the patient's weakened ego, basing themselves on the real external world, have to band themselves together into a party against the enemies, the instinctual demands of the id and the conscientious demands of the super-ego. We form a pact with each other. The sick ego promises us the most complete candour - promises, that is, to put at our disposal all the material which its self-perception yields it; we assure the patient of the strictest discretion and place at his service our experience in interpreting material that has been influenced by the unconscious. Our knowledge is to make up for his ignorance and to give his ego back its mastery over lost provinces of his mental life. This pact constitutes the analytic situation"

Therefore, the subject no longer needs to renounce himself, but to know himself in order that his autonomy and self-mastery are regained. For Nicolas Rose (2010), the idea of the autonomous and knowledgeable self is undissociated from the ideals of autonomy, individuality and freedom which are characteristic of liberalism, where the personal choice will become essential to the government of the subject. However, there are always fissures through which the subject can resist and change the dominant modes of subjectivation. Psychoanalysis also brings with it the importance of interpretation and dialogue, allowing the emergence of alternative narratives and the possibility of a construction of an identity that stems from the idiosyncrasies of each subject (Rorty, 1991). It is from these idiosyncrasies that the importance of the narrative associated with a new form of relationship between truth and subjectivity arises, providing different assemblages of subjectivation (Guattari, 1992). From the idea that the truth about the subject is exterior to him, psychiatry has moved to the belief that truth can be discovered, which in turn opens the way to the notion that truth can be made. From this we can infer two prescriptions, create yourself and control yourself, which will be approached in the next section.

The making of the self

The critique of the subject is a common theme in modern philosophy, sometimes called, in a simplified way, the death of the subject. This critique provoked the emergence of a significant number of questions such as: "What comes after the subject?" (Nancy, 1991) and

“how can I maintain a sense of unicity despite the diversity of components of subjectivation?” (Guattari, 1992, p.16). Maybe we do not need this sense of unicity anymore. Gilles Deleuze and Felix Guattari (1980) were key authors in defending that there should not be subjects but only subjectivation processes which include continuous processes of becoming, individuation and events. In such subjectivation processes, fluxes and machines are more important than structure and language. In their wake, the more recent post-humanism theories propose that subjectivity is an assemblage that includes human and non-human agents (Braidotti, 2013).

Influenced by philosophic and anthropological discourses, the idea of self in psychiatry has also changed and the belief that psychiatry promulgates a unified and fixed conception of self (Rose, 2010) is insufficient to explain the variety of practices behind the different psychotherapies that emerged since the 20th century. The absence of a preconstructed subject, and the emergence of the construct of identity as a result of the relationships between the subject with his context and others, is present in different psychotherapies. For instance, in Narrative Therapy the identity is a result of the interaction between multiple stories and an acceptable outcome of therapy would be the identification or generation of alternative stories, different from the story of the disease, that would enable patients to perform new meanings and identities (White and Epston, 1990). The idea that a dominant narrative creates a lack of personal agency, increases isolation and discourages diversity leads to the theory that therapy must make other powers emerge and provide the context for the generation of other identities. In this case, the therapist becomes a facilitator who, through a therapeutic conversation, ask questions that help the patient to create “landscapes of action and identity” and to develop a new biographic plot. As Michael White and David Epston (1990, pp.61-62) write:

“Re-authoring conversations invite people to continue to develop and tell stories about their lives, but they also help people to include some of the more neglected but potentially significant events and experiences that are “out of phase” with their dominant storylines [...]. The therapist facilitates the development of these alternative storylines by introducing questions that encourage

people to recruit their lived experience, to stretch their minds, to exercise their imagination, and to employ their meanings-making resources”

The therapist should make the right questions to help the patient remember and discover experiences that were forgotten due to the power of the disease and of the dominant cultural practices. The techniques include the externalization of the problem, which means the separation between the problem and the person, and the highlining of unique outcomes, which are situations where the person resisted to the problem. Throughout conversations, a new identity made of new events will emerge, which will be a history of resistance and a better biographic story. If we agree that a better story is also a healthier one, in other words a story that is less painful and reduces the suffering of the subject, we have to remember that the definition of health is always dependent on cultural and social mechanisms of power. So, there is a risk that the better story is also the best adapted to norms, the statistically average and the normal story. For instance, from a story of weakness and failure, piecing together the exceptions to this narrative can bring about a history of strength and success, but the measure of the success would be the same.

If the subject can create himself, he can also control himself and this prescription, control yourself, has become one among the most important in psychiatry. Cognitive psychotherapy is a good example of this prescription. Although the idea of mastery and control is present from the beginning of psychotherapies, and it is not completely separated from the idea of self-knowledge, in cognitive therapy the aim is not the knowledge of one’s unconscious desires to solve the conflict, but to recognize one’s emotions and thoughts in order to control them. One of its main ideas is that the subject can learn skills and the therapist should be his teacher or coach. Those skills help him control and reduce his anxiety, by identifying cognitive distortions, which the individual then acts upon. This is not only a prescription of unspecified control, but of the right control in the right measure. For instance, in Obsessive Compulsive Disorder, the efforts of the subject to control his thoughts are prejudicial and sometimes even excessive

(Clark, 2007). So, the patient should lose control in order to gain other type of control, the correct one.

The therapist, as a coach, should do a detailed assessment to identify the dysfunctional or maladaptive thoughts and behaviors, and obtain a detailed description of each situation or trigger of anxiety, using questionnaires, interviews, rating scales, self-report and also in vivo ratings (Clark and Beck, 2010). Afterwards, he should educate the patient about its pathology and treatment, define the structure and goals of the therapy, question the patient, motivate and guide him, prescribe homework and assign it, promoting alternative thoughts and teaching him how to deal with his thoughts and responses. As Aaron T. Beck and David A. Clark write (2010, p.200):

“One of the first skills taught in cognitive therapy is the ability to identify and record the automatic apprehensive thoughts, images, and appraisals that characterize anxious episodes. In addition, clients write down their observations of the physical and behavioral symptoms of anxiety. Self-monitoring anxious thoughts is a prerequisite skill for cognitive restructuring. It may be necessary to deal with homework noncompliance at this point in therapy”

So, the patient should provide the material for the therapy, accept the model, self-monitoring his thoughts, feelings and behaviours and do the prescribed homework (Clark, 2007). The patient has an important responsibility in his improvement and the resolution of the symptoms results from his own choice and practice. Behavioral interventions (namely, exposure, response prevention, relaxation training and controlled breathing) are an important complement to cognitive therapy that follows the same principles, namely teaching of skills and homework assignments, in order that the subject learns the skills and regains the control over his problem (Clark and Beck, 2010). Recent cognitive-behavioral therapies (CBT), known as the third wave of CBT, include other practices such as the acknowledgement of emotions and eastern technics of meditation. Although there are significant differences between them, these psychotherapies also embrace, among others, the prescription of control and follow this structure of education about the problem and its

treatment, the teaching of skills, the prescription of homework and practice training, enhancing the patient's responsibility for the outcome of the treatment. For instance, in one of the training handouts of Dialectical Behavioral Therapy (DBT) it is said that:

“Emotion Regulation module helps you manage your emotions, even though complete emotional control cannot be achieved. To a certain extent, we all are who we are, and emotionality is part of us; however, we can learn to have more control over them” (Linehan, 2015, p.3)

Regarding responsibility and choice, one of the main processes of Acceptance and Commitment Therapy (ACT) is: “teaching committed behavioral persistence and behavioral change strategies linked to choose values”, defining commitment as a major principle of the therapy (Hayes, 2004, p.15).

In Cognitive Therapy, anxiety is considered to result from the perception of vulnerability (Clark and Beck, 2010) and it is a normal state that protects us from threats. However, it can be magnified by dysfunctional cognitive processes that leave the subject even more vulnerable (Alford and Beck, 1997). As a result, if the subject is at risk, he should regain control in order to protect himself. Control and risk are correlated ideas and are common rationales for the generalization of psychiatry as a dominant subjectivation technology (Vermeulen, 2014). Moreover, the control is also connected to the senses of individuality and responsibility that are linked to the functional and productive subject, who will be analysed in more detail in the last section.

These two prescriptions, create and control yourself, are not entirely distinct from the idea of improvement and enhancement. However, these ideas have an autonomous meaning and have been gaining prominence in psychotherapy in recent years. In the next section there will be a reflection over opposite ethical precepts connected to the prescription of self-improvement.

Improving ourselves

The idea of improvement is inseparable from the idea of care and training of oneself by oneself (Foucault, 1984), and, although it can

be considered that it was already present in the psychiatric practice, it has recently acquired a new centrality. It emerges in the context of pluralization of therapies, experts, models of self, and the multiplication of therapeutic objectives such as those of increased productivity, normalization, resistance, well-being, happiness and solidarity. This article proposes that the idea of improvement in therapy has different conceptualizations and underlying meanings that can be resumed in two opposed categories: the self-improvement on behalf of resistance and ideals of community, and the individual improvement in order to become more productive and efficient. Both are obviously related to different political and ethical discourses.

Regarding the first proposed category, if the subjects can modify themselves, and are not only a product of the subjugating power, they can also create themselves in different ways and oppose the dominant forms of subjectivation. Michel Foucault (2017a), in one of his latest interviews, considers that the care of the self should rather be a practice of freedom and resistance. This idea has been developed by other authors that defend that subjectivation should be an act of creation and would enable a new capacity for enunciation (Rancière, 1995a). This political subjectivation would thus be part of the reconfiguration of the field of experience, producing multiplicity, creating difference and refusing an imposed identity (Rancière, 1995b). Therefore, new subjectivities would be ways of resistance, produced through cooperation and communication, in order to create a shared commonality and an alternative to neoliberal subjectivation (Hardt and Negri, 2009).

The idea that psychotherapies should promote practices of subjectivation that are connected to resistance was already referred when discussing Narrative Therapy, and also underlies other psychiatry practices, such as Community Psychiatry and Open Dialogue methods. In his book *Narrative Practice – Continuing the Conversations*, Michael White (2011, pp.61-62) asks “how might we go about subverting the hierarchies of knowledges that privilege professional knowledge claims and open up new possibilities for dissent?” and formulates a

possible answer:

“in challenging the ethic of control and its account of responsible action, it becomes more possible for us to assist the person to recognize, acknowledge, and honor the steps that they might be taking, or to explore the steps that might be available to them, in the generation of contexts that will be more favorable to the changes that they desire; those steps that provide the foundation of new possibilities in their lives. In working to break from the ethic of control, it becomes possible for us to recognize and to name voices of dissent; to respect and name those actions that constitute a resistance to the dominant social order”

So, these new possibilities of subjectivation are strategies of resistance and dissidence. Another example is the Open Dialogue approach, a community-based treatment originally developed with patients with psychosis. In Open Dialogue, it is affirmed that throughout a dialogical practice the perspective of the patient should be emphasized in order to reach a common understanding. There should be a transformative dialogue without a preconceived hypothesis or specific agenda, focusing in words and stories more than symptoms (Olson et al., 2014). The therapist is a facilitator or “professional helper” that listens more than gives advices, and the content of the session is always brought by the patient and his family. In the therapy, a shared expertise emerges (Seikkula and Arnkil, 2006) and different subjectivities are promoted:

“Increasing subjectivity to the extent that one realizes that objectivity comprises an endless polyphony of subjectivities appears to pave the way to the postmodern expertise with fewer fantasies of control and a high tolerance of uncertainty and curiosity toward others subjectivity” (Seikkula et al., 2003, p.198)

This polyphonic subjectivity, created by the voices of the patient, the family the therapeutic team, will contribute to the empowerment of the patient (Seikkula and Arnkil, 2006) and to create a sense of community (Seikkula and Trimble, 2005). Regarding the problems related to these approaches, as the authors of these therapies recognize and it was already referred previously, therapy is a historically situated technology. Considering that the lack of adaptation and deviance to the norm are present in the concept of mental illness, these “new possibilities in their lives” would be healthier possibilities which could also mean that the subjects would

be more adapted to the political rationalities and power technologies. Another aspect is that if the therapist is not in charge, the control is on the side of the patients and they should be responsible for their improvement and blamed for his failures. Although this is a simplification and both therapies argue that this is not a one-sided control but a shared responsibility that results from collaboration between different subjects with different powers (Seikkula and Arnkil, 2006, White and Epston, 1990), we should not forget that the ideas of care, empowerment and recovery, initially presented as an emancipatory, have been incorporated by neoliberal technologies of autonomy and choice (Hache, 2007). Additionally, the emergence of a “joint language” can have an opposite effect to the intended, obliterating the multiple possibilities of subjectivation and precipitating the homogenization of discourses between patient, therapist and community.

Looking at the second proposed category, the ideas of improvement are also related to the concept of entrepreneurship and to the ideal neoliberal subject. Different from the subject-consumer of the liberalism this is the subject entrepreneur of himself, being his own capital and his own producer (Foucault, 2004). The neoliberal discourse of empowerment, agency and efficiency has been pervasive in psychiatry (Sugarman, 2015), where it is commonly considered that the subject should make his own choices associated with the idea of potentiation of the self, centered on the infallibility of the individual will. This idea is distant from the initial influence of pastoral power, in which the relationship with the therapist was supposed to move towards the elimination of personal will, and also from the obligation to know himself. Instead, self-transformation under neoliberal power is oriented toward the maximization of personal will (Hache, 2007). The subjects are encouraged to make their own life a project, embrace challenges and reinvent themselves in order to develop a lifestyle that maximizes their existence. For instance, in another DBT sheet it is written:

“you will be encouraged to identify your own personal goals. You will also be oriented to the format, rules, and meeting times of your particular skills program.

[...] These skills are central in DBT: they teach how to observe and experience reality as it is, to be less judgmental and to live in the moment with effectiveness. [...] Interpersonal effectiveness module help you manage interpersonal conflicts effectively and maintain and improve relationships with other people” (Linehan, 2015, pp.1-2)

It can be seen that the concepts of goals, effectiveness, efficiency, management, improvement, and also of contracts and psychological flexibility (Hayes, 2004) are present in contemporary psychotherapies. Neuroscientific developments, namely neuroenhancers and genetic modification, did not change this prescription, but increased it, based on an idea of a self-produced by the brain (“an organic-self”) that can be modified and whose abilities must be boosted. While some authors criticize the constant externalization of objectives and passivity linked to practices of enhancement (Sloterdijk, 2013) and emphasize its differences from the ideas of self-discovery and aesthetics of existence of Antiquity (Foucault, 2017b), others defend that enhancement also favours internal changes such as self-esteem and mental energy, and argue that individual wellbeing can also increase social goods. For example, enhancement can promote altruism, compassion, originality, lack of social and gender prejudice and “useful forms of economic productivity” (Bostrom and Sandberg, 2009). Besides this, it can be argued there is no substantial difference between therapy and enhancement because treatment of diseases is already a way of improving our performances (Hall, 2017).

This leads to the question if there is an alternative to the idea of the self-made, improved and neoliberal subject. Or have these concepts have become so omnipresent that they do not belong to a unique political rationality anymore? Although the absence of a predefined subject potentiates the idea of improvement of the self, as this article shows, not all the psychiatric prescriptions have a neoliberal basis, but some have critical and anticapitalistic foundations. While some highlight the idea of the individual, its skills and capabilities, others emphasize the ideas of cooperation and community. Meanwhile, both point to an idea of an ideal subject and contain in themselves the adequate techniques

of governing it.

CONCLUSION

This article traces the different ways through which the subject has been construed over time and the different ethical prescriptions in the psychiatric practice, using some psychotherapies models to exemplify it. From the imposition of truth to the importance of self-knowledge, psychiatry has moved to the idea of the creation of the self, which is imminently connected to the obligation of control. Both these prescriptions can lead to an idea of improvement: either as a means to resist power and create a new subjectivity, or as an injunction for one to challenge and overcome his own self. From a perspective that the subject should be trained in order to be healthier, psychiatry evolved to the subject as the trainer of himself. Accordingly, a pastoral model was followed by educational practices and afterwards by an entrepreneurial model of the relationship between therapist and patient. These different prescriptions and relations are not totally opposed to one another, and sometimes are present simultaneously in the psychiatric field. For instance, in forensic expertise or compulsory treatments, the imposition of truth as a way of proof or restraint is still the dominant prescription, even though it can be mingled with others.

After the impact of the critique of the subject in amounts to psychiatry, a return to the ideal subject and to the necessity of its right government has gained a new emphasis, which had never really disappeared. Answering a question made previously, what comes after the subject is the subject. Based on this, several questions emerge: is that necessarily bad? Do we need an ethical prescription to control and improve ourselves in order to live the best life? It would be easy to answer that it all depends on the way improvement and control are used (Seikkula and Arnkil, 2006). For example, if control is a way of domination of the subject, who should be normalized in order to avoid conflicts and inadaptation, then it must be avoided, while if it is to be used to reduce the subject's suffering and increase his power over his own life, then it would be helpful. A similar approach can be

used with the idea of improvement, it is good if it leads the subject towards a healthier life. However, this is not only a simplistic answer is also a manichaeian one. Firstly, health and suffering are dependent of political rationalities and secondly, these processes of creation and subjection, resistance and domination, are never entirely separated. Gilles Deleuze (2004/1986, p.113) said that "*La lutte pour la subjectivité se présente alors comme droit à la différence, et droit à la variation, à la métamorphose*" and this should be the right to sometimes conform and others reject the subjectivation processes present in the psychiatric field.

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